TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2051
PREFERRED PROVIDER PROGRAM ADMINISTRATORS

Section

AUTHORITY: Implementing and authorized by Article XX 1/2 and further authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/370f and 401].

SOURCE: Adopted at 20 Ill. Reg. 9960, effective July 15, 1996; expedited correction at 20 Ill. Reg. 13435, effective July 15, 1996; amended at 21 Ill. Reg. 16364, effective December 9, 1997; expedited correction at 22 Ill. Reg. 5126, effective December 9, 1997.

Section 2051.10 Authority

This Part implements and is authorized by Article XX 1/2 and is authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/370f et seq. and 401].

Section 2051.20 Purpose

The purpose of this Part is to implement Article XX 1/2 of the Illinois Insurance Code which, in part, provides for the regulation of administrators of preferred provider programs. This Part defines the authority of an administrator to operate preferred provider programs in this State, establishes criteria for the registration of administrators with the Director of Insurance and establishes appropriate fees for the registration and regulation of such programs. This Part applies only to administrators of preferred provider programs subject to Article XX 1/2 of the Illinois Insurance Code.

(Source: Amended at 21 Ill. Reg. 16364, effective DEC 09 1997)

Section 2051.30 Definitions

Administrator means any person, partnership or corporation, other than an insurer or health service corporation or health maintenance organization holding a certificate of authority under the Health Maintenance Organization Act, [215 ILCS 125/1-1], or self-insured employer, employee benefit trust fund or other ERISA exempt organization, that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.

An affiliate of, or person "affiliated" with, a specific person means a person that directly, or ~~in~~directly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Beneficiary means an individual entitled to reimbursement for covered expenses of, or the discounting of provider fees for, health care services under a program where the beneficiary has an incentive to utilize the services of a provider which has entered into an agreement or arrangement with an administrator pursuant to Section 370g(f) of the Illinois Insurance Code [215 ILCS 5/370g(f)].

Control (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of policies of a person, whether through the ownership of voting securities, the holding of policyholders' proxies by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is solely the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds shareholders' proxies representing 10% or more of the voting securities of any other person, or holds or controls sufficient policyholders' proxies to elect the majority of the board of directors of the domestic company. This presumption may be rebutted by a showing made in the manner as the Director may provide by rule.

The Director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Director means the Director of the Illinois Department of Insurance.

Emergency means an accidental bodily injury or emergency medical condition that reasonably requires the beneficiary or insured to seek immediate medical care under circumstances, or at locations which reasonably preclude the beneficiary or insured from obtaining needed medical care from a preferred provider pursuant to Section 370g(h) of the Illinois Insurance Code [215 ILCS 5/370g(h)].

Financial Institution means a Federal or State chartered bank(s) or savings and loan institution.

Gatekeeper Option means an option offered by or through a preferred provider program that requires the beneficiary to preselect a particular primary care physician from a list of participating primary care physicians, who shall coordinate all of the non-emergency primary, specialty, hospital and other health care services, including referrals to other providers, as a condition for receipt of a higher level of benefits or reimbursement level, or both.

Health Care Services means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision and pharmaceutical services or products.

Health Service Corporation means a voluntary health service plan and/or a dental service plan licensed under the applicable Sections of Chapter 215 of the Illinois Compiled Statutes.

Non-preferred Provider means any provider that does not have a contractual relationship with the administrator.

Payor means an entity responsible for bearing the risk of health care services. An Administrator is prohibited from being a payor.

Primary Care Physician means a provider who has contracted with an administrator to provide primary care services as defined by the contract and who is a physician licensed to practice medicine in all of its branches who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics or family practice, or a chiropractic physician licensed to treat human ailments without the use of drugs or operative surgery (77 Ill. Adm. Code 240.2).

Provider means an individual or entity duly licensed or legally authorized to provide health care services.

Preferred Provider means any provider who has entered into an agreement with an administrator relating to health care services which may be rendered to beneficiaries under a preferred provider program.

Preferred Provider Arrangements means policies, agreements or arrangements with providers relating to the amounts to be charged to beneficiaries for health care services which can include incentives for the beneficiary to use such services.

Preferred Provider Program means a system to make preferred provider arrangements available to beneficiaries.

Woman's Principal Health Care Provider means a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology.

(Source: Amended at 21 Ill. Reg. 16364, effective DEC 09 1997)

Section 2051.40 Administrators Not to Assume Underwriting Risk

An administrator may negotiate and make arrangements with providers in compliance with Article XX 1/2 of the Illinois Insurance Code, and market and otherwise make available such arrangements to insurance companies, health service corporations, fraternal benefit societies or self-insuring employers or health and welfare trust funds and to their subscribers; provided however, that in performing such functions the administrator shall not accept any underwriting risk in the form of a premium or capitation payment for its services.

Section 2051.50 Registration

a) No person, partnership or corporation shall act as an administrator of a preferred provider program until such time that such person, partnership or corporation has registered with the Director as required by this Part. In addition, all administrators shall annually register with the Director as required by this Part. Annual registration statements must be filed with the Director no later than January 1st of each year.

b) Each administrator must keep current the information required to be disclosed in its registration statements by reporting all material changes or additions to the Director within 30 days after the end of the month of each change or addition. A material change or addition includes any modification of the information required by Section 2051.55 of this Part that has significant effect on the operation of the administrator or on the availability and accessibility of health care.

c) No Administrator shall offer any preferred provider program to residents of this State until the Director has determined that the requirements of Article XX 1/2 of the Illinois Insurance Code [215 ILCS 5/370f] and this Part have been met, and has placed such registration material on file. The Director shall make such determination within 60 days after receipt of the registration information required by this Section and the registration fee required by Section 2051.60 of this Part.

d) All information filed with the Director pursuant to this Part regarding the methods and/or amounts of reimbursement of providers and the administrator under the preferred provider program(s) is deemed to be confidential and will not be released without subpoena or written consent of the affected administrator.

(Source: Amended at 21 Ill. Reg. 16364, effective DEC 09 1997)

Section 2051.55 Administrator Application Filing Procedures

Each applicant for registration shall file with the Director the following information and documents in the format specified by Exhibits A, B & C of this Part:

a) An organizational chart describing the relationship between the administrator, its parent organization and any affiliates, including the state of domicile and the primary business of each entity; and

b) A list of the names, addresses, official positions and biographical affidavits of the persons responsible for the conduct of the affairs of the administrator; and

c) Sample copies of administrative agreements, payor agreements and provider agreements utilized by the administrator. If the terms and conditions in such agreements include significant substantial or material variations, the filing of one complete sample agreement together with a description of all variable terms and conditions will satisfy this requirement.

1) The payor agreements shall contain:

A) Terms requiring that incentives be provided to the insured or beneficiary to utilize services of a provider that has entered into an agreement with the administrator.

B) Terms stating that, whenever an administrator or a preferred provider finds it medically necessary to refer a beneficiary to a non-preferred provider the payor shall ensure that the beneficiary so referred shall incur no greater out of pocket liability than had the beneficiary received services from a preferred provider. A beneficiary who willfully chooses to access a non-preferred provider for health care services available through the administrator panel of preferred providers will be subject to financial penalties as prescribed by the payor.

C) Terms requiring the administrator's name and toll-free "800" telephone number to be contained on the beneficiary identification card issued by the payor.

2) The provider agreements shall contain, at a minimum, the following:

A) A provision identifying the specific covered health care services for which the preferred provider will be responsible, or a provision describing the method by which the preferred provider will be notified of the particulars of the coverage. Copayments, benefit maximums, limitations and exclusions shall be enumerated or appropriately referenced.

B) A provision requiring the provider to comply with applicable administrative policies and procedures of the administrator.

C) A provision requiring the provider to cooperate with and participate in the administrator credentialing and recredentialing processes if any.

D) A provision requiring the provider to participate in and cooperate with the decisions, policies, processes and rules established by the administrator utilization review (utilization management) program including, but not limited to, certification procedures, concurrent and retrospective evaluations, referral procedures, and reporting of clinical encounter data.

E) A provision requiring the provider to maintain and make medical records available to the administrator for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to administrator beneficiaries, and to make such medical records available to appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints and to comply with the applicable State and federal laws related to privacy and confidentiality of medical records.

F) A provision requiring providers to be licensed by the State, and to notify the administrator immediately whenever there is a change in licensure or certification status.

G) A provision requiring all physician providers to have admitting privileges in at least one hospital with which the administrator has a written provider contract. The administrator shall be notified immediately of any changes in privileges at any hospital or admitting facility. Reasonable exceptions may be made for physicians who, because of the type of clinical specialty, or location or type of practice, do not customarily have admitting privileges.

H) A provision describing notification procedures for contract termination. Provider contracts shall require no less than 30 days prior written notice by either party who wishes to terminate the contract without cause provided, however, that the administrator may terminate the provider contract for cause immediately. The administrator of a gatekeeper option shall make a good faith effort to provide written notice of termination to all beneficiaries who are patients seen on a regular basis by a provider whose contract is terminating. Where a contract termination involves a primary care physician, in a gatekeeper option, all beneficiaries who are patients of that primary care physician shall also be notified. The provider contract for a gatekeeper option shall contain provisions whereby within five working days after the date that the provider either gives or receives notice of termination, the provider shall supply the administrator with a list of those patients of the provider who are covered by a plan using the administrator's network.

I) A provision explaining the provider responsibilities for continuation of covered services in the event of contract termination, to the extent that an extension of benefits is required by law or regulation, or that such continuation is voluntarily provided by the administrator.

J) A provision stating that the rights and responsibilities under the contract cannot be sold, leased, assigned or otherwise delegated by either party without the prior written and informed consent of the other party.

K) A provision stating that the preferred provider has and will maintain adequate professional liability and malpractice coverage, through insurance, self funding, or other means satisfactory to the administrator. The administrator must be notified within no less than ten days of the provider's receipt of notice of any reduction or cancellation of such coverage.

L) A provision stating that the provider will provide health care services without discrimination against any beneficiary on the basis of participation in the preferred provider program, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability.

M) A provision regarding the preferred provider's obligation, if any, to collect applicable copayments and/or deductibles from beneficiaries pursuant to the evidence of coverage, and to provide notice to beneficiaries of their personal financial obligations for non-covered services.

N) A provision regarding any obligation to provide covered health services on a 24-hour per day, 7 day per week basis.

O) A provision identifying the mechanism for provider access to each payor's current eligibility data system.

P) A provision clearly describing payment obligations to the provider.

Q) A provision identifying the administrative services, if any, the administrator will perform and the types of information (financial, enrollment, utilization, improvement) that will

be submitted to the provider as well as other information that is accessible to the provider.

R) A provision obligating the administrator to provide a method for providers to access each payor to obtain initial information and adequate notice of change in benefits and copayments, and a provision obligating the administrator to provide all of the administrator's operational policies.

S) A provision identifying applicable internal appeal or arbitration procedures for settling contractual disputes or disagreements between the administrator and preferred provider, and

d) A general statement of the services to be offered through the administrator's proposed plan of operations, including:

1) The method of marketing the program;

2) A geographic map of the area proposed to be served by the program by both county and zip code, including marked locations of preferred providers;

3) The names and addresses of the providers with whom the administrator has entered into agreements;

4) The number of beneficiaries covered by the agreements listed in subsection 2051.55(d)(3) of this Section;

5) A source for the beneficiary to contact regarding changes in such providers, and

e) A description of the standards by which the administrator assures that the health care services to be rendered under the preferred provider program are reasonably accessible and available to beneficiaries. Standards shall address such issues as:

1) The scope of health care services to be provided by the administrator network.

2) The number and type of providers necessary to:

A) Meet the health care needs and service demands of the currently enrolled population, including:

i) Provider-beneficiaries ratio by specialty.

ii) Primary care provider-beneficiaries ratio.

iii) Waiting times for appointments with preferred providers.

iv) Hours of operation.

v) Volume of technological and specialty services available to serve the needs of beneficiaries requiring technologically advanced or specialty care.

B) Meet the health care needs and service demands of the population expected to be enrolled over the next 12 months, including:

i) Provider-beneficiaries ratio by specialty.

ii) Primary care provider-beneficiaries ratio.

iii) Waiting times for appointments with preferred providers.

iv) Hours of operation.

v) Volume of technological and specialty services available to serve the needs of beneficiaries requiring technologically advanced or specialty care.

3) The location of providers within the service area necessary to accommodate the enrolled population.

4) The distance or time that the beneficiary must travel to access:

A) Hospital services including 24 hour emergency department services;

B) Primary care and Woman's Principal Health Care physician services;

C) Specialty care physician services.

5) The addition of providers to meet patient needs based on increases in the number of beneficiaries, changes in the patient to provider ratio, changes in medical and health care capabilities, and increased demand for services.

6) The provision of 24 hour, 7 day per week access to network affiliated primary care and woman's principal health care provider.

7) The procedures for making referrals within and outside the network.

8) The process for enabling beneficiaries to select and change primary care physicians and to select and change woman's principal health care providers (Gatekeeper Option).

9) Efforts to address the needs of beneficiaries with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

10) Policies and procedures to assure access to covered services when:

A) The covered service is not available from a network provider; in any case whereby a beneficiary has made a good faith effort to utilize network providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost than if the service had been provided by a preferred provider.

B) The beneficiary has a medical emergency within the network service area;

C) The beneficiary has a medical emergency outside the network's service area, and

f) Copies of the preferred provider program disclosure statements required to be furnished to beneficiaries by Section 370m of the Illinois Insurance Code, [215 ILCS 5/370m] and corollary advertising material; and

g) A description of programs for utilization review including procedures for timely investigation, resolution of questions, and appeals from beneficiaries and providers.

h) A description of any fiduciary account established by the administrator, including the location and identification number of the account, established and maintained pursuant to Section 370e of the Illinois Insurance Code [215 ILCS 5/370e] and Section 2051.70(a) of this Part; and/or a bond in compliance with Section 370e of the Illinois Insurance Code [215 ILCS 5/370e] and Section 2051.70(b) of this Part. If a bond is submitted the administrator shall also furnish a certification of the total estimated annual reimbursements under the preferred provider program(s), supported by the methodology used to arrive at such figure; and

i) Location of the administrative offices of the administrator located in this State and regular business hours during which offices are open; and

j) Credentialing materials including, but not limited to:

1) Written policies and procedures for credentialing verification of all health care professionals with whom the administrator contracts;

2) Written policies and procedures for determining when the network is closed to new providers desiring to enter the network;

3) Written policies and procedures for adding providers to closed network when openings become available due to attrition or expansion; and

k) Such other information as the Director may reasonably request.

(Source: Added at 21 Ill. Reg. 16364, effective DEC 09 1997)

Section 2051.60 Fees

On or after January 1, 1998, each new administrator doing business in this State shall pay to the Director of Insurance a an initial registration fee of $250. Annually on or before January 1 of each succeeding year and each administrator doing business in this State shall pay to the Director a renewal fee of $150 in order to maintain such registration.

(Source: Amended at 20 Ill. Reg. 16364 effective DEC 09 1997)

2051.65 Gatekeeper Option

An insurer or administrator, otherwise meeting the standards of this Part, may make available a gatekeeper option as an incentive to utilize the services of a preferred provider. Such products must meet applicable accessibility and availability of care standards as set forth in Section 2051.55(e) of this Part and comply with requirements of Section 356r of the Illinois Insurance Code [215 ILCS 5/356r].

(Source: Added at 21 Ill. Reg. 16364, effective DEC 09 1997)

Section 2051.70 Fiduciary and Bonding Requirements

a) This Section outlines requirements for administrators who must establish either a bond or a fiduciary account pursuant to Section 370(1) of the Illinois Insurance Code.

b) Administrators who establish and maintain a fiduciary account pursuant to Section 370(1) of the Illinois Insurance Code are subject to the following requirements:

1) Monies collected for reimbursement under preferred provider programs which the administrator holds more than 15 days shall be deposited in a special fiduciary account in a financial institution located in this State, which account shall be designated as an "Administrator Trust Fund", hereinafter referred to as "ATF". All checks drawn on the ATF shall indicate on their face that they are drawn on the ATF of the administrator.

2) An administrator that operates more than one preferred provider program may establish separate fiduciary accounts for each program, or may maintain a consolidated fiduciary account for such programs. If a consolidated Administrator Trust Fund account is maintained the administrator's records shall clearly indicate for each program fund deposits and disbursements.

3) No disbursement shall be made from the Administrator Trust Fund account other than payment for provider services under the preferred provider programs(s) operated by the administrator and administrative fees due the administrator pursuant to a written agreement.

4) For each preferred provider program for which an ATF is maintained, the balance in the ATF shall at all times be the amount of funds deposited plus accrued interest, if any, less authorized disbursements.

5) If the ATF is interest bearing or income producing, the full nature of the account must first be disclosed to the principal, whether insurer or other

payor of services under the preferred provider program, on whose behalf the funds are or will be held. At this time the administrator must procure the written consent and authorization from this principal for the investment of money and retention of interest or earnings.

6) An administrator may place ATF funds in interest bearing or income producing investments and retain the interest or income thereon, providing the administrator obtains the prior written authorization of the principals on whose behalf the funds are to be held. In addition to savings and checking accounts, an administrator may invest in the following:

A) Direct obligations of the United States of America or U.S. Government agency securities with maturities of not more than one year;

B) Certificates of deposit, with a maturity of not more than one year, issued by the Federal Deposit Insurance Corporation (FDIC) or Federal Savings and Loan Insurance Corporation (FSLIC), so long as any deposit does not exceed the maximum level of insurance protection provided to certificates of deposits held by such institutions;

C) Repurchase agreements with financial institutions or government securities dealers recognized as primary dealers by the Federal Reserve System provided:

i) The value of the repurchase agreement is collateralized with assets which are allowable investments for ATF funds; and

ii) The collateral has a market value at the time the repurchase agreement is entered into at least equal to the value of the repurchase agreement;

iii) The repurchase agreement does not exceed 30 days;

D) Commercial paper, provided the commercial paper is rated at least P-1 by Moody's Investors Service, Inc. or at least A-1 by Standard & Poor's Corporation;

E) Money Market Funds, provided the money market fund invests exclusively in assets which are allowable investments pursuant to subsection (A) through (D) of this Section for ATF funds;

F) Each investment transaction must be made in the name of the administrator's ATF. The administrator must maintain evidence of any such investments. Each investment transaction must flow through the administrator's ATF.

7) Recordkeeping

A) Administrators shall maintain detailed books and records which reflect all transactions involving the receipt and disbursement of funds in the ATF.

B) The detailed preparation, journalizing and posting of such books and records must be maintained on a timely basis and all journal entries for receipts and disbursements shall be supported by evidential matter, which must be referenced in the journal entry so that it may be traced for verification. Administrators shall prepare and maintain monthly financial institution account reconciliations of any ATF established by the administrator. The minimum detail required shall be as follows:

i) The sources, amounts and dates of monies received and deposited by the administrator.

ii) The date and person to whom a disbursement is made. If the amount disbursed does not agree with the amount billed or authorized, the administrator shall prepare a written record as to the reason.

iii) A description of the disbursement in such detail to identify the source document

substantiating the purpose of the disbursement.

c) An Administrator who posts or causes to be posted a bond of indemnity pursuant to Section 370(1) of the Illinois Insurance Code shall do so subject to the following requirements:

1) An administrator who operates more than one preferred provider program subject to Article XX 1/2 of the Illinois Insurance Code may maintain a bond of indemnity for any of such programs.

2) The bond shall be held by the Director of Insurance in favor of the beneficiaries and payors of services under the preferred provider program(s) operated by the administrator. The bond shall be executed by a surety company and payable to any party injured under the terms of the bond.

3) The bond shall be in continuous form and shall be in the amount of not less than 10% of the total estimated annual reimbursements under the preferred provider program(s) covered by the bond. The amount of the bond shall be determined in accordance with the methodology submitted by the administrator pursuant to Section 2051.50(c)(8) of this Part.

4) Such bond shall remain in force and effect until the surety is released from liability by the Director or until the bond is cancelled by the surety. The surety may cancel the bond and be released from further liability thereunder upon 30 days written notice in advance to the Director. Such cancellation shall not affect any liability incurred or accrued thereunder before the termination of the 30-day period. Upon receipt of any notice of cancellation, the Director shall immediately notify the administrator.

Section 2051.80 Maintenance of Records

a) All administrators shall maintain detailed books and records of all of their transactions as an administrator of preferred provider programs. The records required to be maintained by this Section shall include:

1) the books and records of ATF transactions required by Section 2051.70 of this Part;

2) books and records regarding all funds received or disbursed by the administrator;

3) all contracts or agreements with providers, insurers or other payors of the services under a preferred provider program; and

4) All documents relating to the administrator's preferred provider program, including but not limited to beneficiary disclosure documents required by Section 370m of the Illinois Insurance Code, beneficiary complaints and documents relating to the administrator's utilization review program.

b) Records shall be maintained for at least three years after the termination of the preferred provider program to which they relate.

Section 2051.85 Advertising and Solicitation

a) No preferred provider administrator or its representative shall cause, or knowingly permit the use of, advertising that is untrue or misleading, or any solicitation that is untrue or misleading.

b) No preferred provider administrator may represent or describe itself in its name, contracts or literature as a "health maintenance organization" or "HMO", nor may it hold itself out or represent itself as being an insurance company or a Limited Health Service Corporation.

(Source: Added at 21 Ill. Reg. 16364, effective DEC 09 1997)

Section 2051.90 Examination

a) The Director or his designee may examine any applicant for registration or any registrant when he obtains information which gives him reason to believe that the applicant or registrant may be in violation of this Part or any applicable provision of the Illinois Insurance Code, when he receives a complaint or when the applicant has a history of violations of the Illinois Insurance Code.

b) Any administrator being examined shall provide to the Director or his designee convenient and free access, at all reasonable hours at their offices, to all books, records, documents and other papers relating to such administrator's business affairs. The Director or his designee shall not have access to beneficiary medical records which are protected by the Medical Studies Act [735 ILCS 5/8-2101 et seq.].

c) The Director or his designee may administer oaths and thereafter examine any individual about the business of the administrator.

d) The expenses of examination under this Section shall be assessed against the administrator being examined in accordance with Section 408(3) of the Illinois Insurance Code [215 ILCS 5/408(3)].

e) The examiner designated by the Director shall make a written report if he alleges that there is a violation of this Part, any applicable provisions of the Illinois Insurance Code or any other applicable Part of Title 50 of the Illinois Administrative Code. The report shall be verified by the examiner. The report must be made to the Director within 45 days after the conclusion of the examination. If no report is to be made, the administrator shall be so notified.

f) If a report is made, the Director shall either deliver a duplicate thereof to the administrator being examined or send such duplicate by certified or registered mail to the administrator's address specified in the records of the Department. The Director shall afford the administrator an opportunity to request a hearing to object to the report. The administrator may request a hearing within 30 days after receipt of the duplicate

of the examination report by giving the Director written notice of such request together with written objections to the report. Any hearing shall be conducted in accordance with Sections 402 and 403 of the Illinois Insurance Code [215 ILCS 5/402 and 403] and 50 Ill. Adm. Code 2402 . The right to hearing is waived if the delivery of the report is refused or the report is otherwise undeliverable to the address on file with the Department or the administrator does not timely request a hearing. After the hearing or upon expiration of the time period during which an administrator may request a hearing, if the examination reveals that the administrator is operating in violation of any applicable provisions of the Illinois Insurance Code, any applicable Part of Title 50 of the Illinois Administrative Code or prior order, the Director, in the written order, may require the administrator to take action to correct such violation in accordance with the report or examination hearing. If the Director issues an order, it shall be issued within 90 days after the report is filed, or if there is a hearing, within 90 days after the conclusion of the hearing. The order is subject to review under the Administrative Review Law.

Section 2051.100 Severability

If any Section, term or provision of this Part shall be adjudged invalid by a court of competent jurisdiction for any reason, such judgment shall not affect, impair or invalidate any other Section, term or provision of this Part, and the remaining Sections, terms and provisions shall be and remain in full force and effect.

Section 2051.EXHIBIT A Preferred Provider Program Administrator Registration Form–PPA 1

Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

Instructions:

Fee Requirement: Attach a check or money order payable to the Director of Insurance for $250.

Name of Firm		Tax #
Business Address (Number, Street)	Phone No.	Fax No.
City	State	Zip Code
Person responsible for submitting application		Phone No.

The following items must be filed with this registration and are, by reference, made a part of this registration form.

1. A general statement of the services to be offered in Illinois through the administrator's proposed plan of operations, including:

   (a) the method of marketing the program;
   (b) a geographic map of the area proposed to be served by the program with marked locations of medical providers;
   (c) a table showing breakdown of providers by type (i.e. hospital, primary care physician, specialist) by county;
   (d) a table showing breakdown of providers by type (i.e. hospital, primary care physician, specialist) by zip code;
   (e) an estimation of the number of beneficiaries projected to be served by the Administrator;
   (f) the names and addresses of the providers with whom the administrator has entered into agreements (provider directory);
   (g) a source for the beneficiary to contact regarding changes in the provider directory;
   (h) an organizational chart describing the relationship between the administrator, its parent organization and any affiliates, including the state of domicile and the primary business of each entity.

2. A list of the names, addresses, official positions and biographical affidavits **(form attached)** of the persons responsible for the conduct of the affairs of the administrator.

3. Sample copies of administrative agreements, payor agreements and provider agreements utilized by the administrator. If the terms and conditions in such agreements may vary, the filing of one complete sample agreement together with a description of all variable terms and conditions will satisfy this requirement.

4. A description of the standards by which the administrator assures that the health care services to be rendered under the preferred provider program are reasonably accessible and available to beneficiaries.

5. Copies of the preferred provider program disclosure statements required to be furnished to beneficiaries by 215 ILCS 5/370m, and correlary advertising material.

6. A description of programs for utilization review and timely resolution of questions, complaints and grievances.

7. Location of the administrative offices of the administrator located in this State and regular business hours during which offices are open.

(OVER)

8. A description of provider credentialing standards utilized by the administrator and a statement describing how the administrator intends to comply with 215 ILCS 5/370h.

9. A completed Bond/Fiduciary Account Requirement Form **(form attached)** or a written statement of exemption to this requirement;

10. The name, address and telephone number of the person within the administrator to whom all notices and renewal applications should be directed.

Declaration:

The undersigned declares that the statements made in this application are true, correct and complete to the best of his/her knowledge and belief.

Signature	**Date**
Print Name and Title	**Phone**

Important Notice: Under the Illinois Revised Statutes' Insurance Laws, disclosure of this information is **voluntary**; however, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

(Source: Expedited correction at 22 Ill. Reg. 5126, effective December 9, 1997)

EFFECTIVE DATE

DEC 09 1997

SOS - CODE DIV

Section 2051.EXHIBIT B Biographical Affidavit

Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

Full name and address of company (do not use group names)
In connection with the above-named company, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) **If answer is "No" or "None," so state.**
1. Affiant's full name (initials not acceptable)
2a. Have you ever had your name changed?_____ If yes, give the reason for the change. _____
2b. Give other names used at any time
3. Affiant's Social Security # / **4. Date and place of birth**
5. Affiant's business address / **Business Telephone #**
6. List your residences for the last ten (10) years starting with your current address, giving:
Date / **Address** / **City and State**
7. Education: List dates, names, locations and degrees
College:
Graduate Studies:
Others:
8. List memberships in Professional Societies and Associations
9. Present or proposed position with the applicant company
10. List complete employment record (up to and including present jobs, positions, directorates or officerships) for the past twenty (20) years, giving:
Dates / **Employer and Address** / **Title**
Please circle one:
11. May present employer be contacted? Yes No / **May former employers be contacted? Yes No**
12a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details. _____
12b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond cancelled or revoked? _____ If yes, give details. _____

13. List any professional, occupational, and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (state date, license issued, issuer of license, date terminated, reasons for termination.)

14. During the last ten (10) years, have you ever been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked? _____ If yes, give details.

15. List any administrators, insurers or HMOs in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock standing stock (in voting power). _____

If any of the stock is pledged or hypothecated in any way, give details. _____

16. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of the applicant administratoror its affiliates? _____ If any of the shares of stock are pledged or hypothecated in any way, give details. _____

17. Have you ever been adjudged bankrupt?_____

18. Have you ever been convicted or had a sentence imposed or suspended or had pronouncement of a sentence suspended or been pardoned for conviction of or pleaded guilty or nolo contendere to any information or,an indictment charging any felony, or charging a misdemeanor involving embezzlement, theft, larceny, or mail fraud, or charging a violation of any corporate securities statute or any insurance law, or have you been the subject of any disciplinary proceedings of any federal or state regulatory agency? _____ If yes, give details. _____

19. Has any company been so charged, allegedly as a result of any action or conduct on your part? _____ If yes, give details. _____

20. Have you ever been an officer, director, trustee, investment committee member, key employee, or controlling stockholder of any insurer, HMO or administrator which, while you occupied any such position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship?_____

21. Has the certificate of authority or license to do business of any insurance company or registration of any administrator of which you were an officer or director or key management person ever been suspended, revoked or denied while you occupied such position? _____ If yes, give details.

Declaration

Dated and signed this _____ day of _____ at _____.
I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____

State of _____

County of _____

Personally appeared before me the above named _____
personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 19_____.

_____
(Notary Public)

(SEAL)

My commission expires _____.

Important Notice: Disclosure of this information is **required** under Illinois Departmental Rules. This form has been approved by the Forms Management Center.

Printed on recycled paper.

(Source: Added at 21 Ill. Reg. 16364, effective DEC 09 1997)

Section 2051.EXHIBIT C Preferred Provider Program Administrator Bond/ Fiduciary Account Requirement

Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

Instructions:

Bond/Fiduciary Account Requirement: Registrations of Preferred Provider Program Administrators who will handle money for purposes of payment for providers services must be accompanied by:

1. A surety bond in an amount equal to not less than 10% of the total estimated annual reimbursements under the program. **If more than one program is administered, separate bonds may be posted for each program or one bond of indemnity may be posted for all. Administrators posting a bond or bonds must also submit certification of the total estimated annual reimbursements under the Preferred Provider Program (or programs if separate bonds are posted), supported by methodology used to arrive at such figures.**

   The surety bond(s) must contain:

   - The name of the principal as it appears on the registration form;
   - The principal's address as it appears on the registration form;
   - The surety company's name and company number;
   - The bond number;
   - Original signatures of the Illinois resident agent, principal, the surety company's officer or attorney-in-fact.

2. Or, **in lieu of bond**, the Preferred Provider Program Administrator may establish one or more fiduciary accounts, separate and apart from any and all other accounts, for the receipt and disbursement of funds for reimbursement of providers of services under the program.

Location of Account _____

_____

Account Identification No. _____

(In the event that **both** bonds and fiduciary accounts are established, disclose information about both as requested above.)

Bond(s)	Methodology	Fiduciary Account(s)	Loc/ID #

(Do not write in these spaces.)

Illinois Department of Insurance
320 W. Washington Street
Springfield, IL 62767-0001

Preferred Provider Program Administrator Bond

Co. Code No. _____

Bond No. _____

KNOW ALL MEN BY THESE PRESENTS, THAT I/we _____

of _____, a Preferred Provider

Program Administrator, as principal and _____
a company duly authorized to transact surety business in the State of Illinois, as Surety, are held and firmly bound unto the People of the State of Illinois and payable to any party injured under the terms and conditions of this bond, in the full and penal sum of _____($) dollars lawful money of the United States of America, for the payment of which, well and truly to be made, we bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

THE CONDITION OF THIS OBLIGATION IS SUCH that the above bounded Principal is now or is about to register in order to engage or continue in the business of a Preferred Provider Program Administrator, as provided by the Illinois Insurance Code, as amended.

NOW, THEREFORE, if the said Principal shall, while this bond is in force and effect make a full accounting and due payment to the person or company entitled thereto of funds coming into his possession as an incident to Preferred Provider Program Administrator transactions, and shall comply with all the provisions of Article XX1/2 of the Illinois Insurance Code, as amended; then this obligation shall be null and void; otherwise to remain in full force and effect.

PROVIDED, HOWEVER, that this bond shall be continuous in form and may be terminated by the Surety, upon its giving thirty (30) days notice of its intention of termination, such notice to be filed with the Director, Department of Insurance, Springfield, Illinois.

IN WITNESS WHEREOF, the said principal has hereunto set his hand and seal, and the said surety has caused these presents to be signed by its duly authorized officers and its corporate seal to be hereto affixed this _____ day of _____, 19____.

Countersigned by:

_____
(Signature of Appointed Illinois Producer)

At _____, Illinois

_____
(Bonding Company)

_____
(Signature of Company Officer)

_____
(Signature of Attorney-In-Fact)

_____
***(Signature of Principal)–Social Security #**

_____

_____

***If a Corporation, signature and social security number of an officer.**

Important Notice: Under the Illinois Revised Statutes' insurance laws, disclosure of this information is **voluntary**; however, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

(Source: Added at 21 Ill. Reg. 16364, effective DEC 09 1997)